

# CAMP ALEXANDER MACK, INC.

## High Ropes Community Day Registration

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

(check if you do not wish to be on our email list) \_\_\_\_\_

Allergies: \_\_\_\_\_

Special Needs/Accommodations: \_\_\_\_\_

If Participant is a minor: (Emergency contact also required):

Parent Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

### **Waiver and Release Statement:**

High Ropes courses (challenge courses) are potentially dangerous. I recognize that certain hazards and dangers are inherent in challenge course events and programs. I understand, also, that although Camp Mack has taken precaution to provide proper supervision, instruction, training, and equipment for each activity, it is impossible for the camp to guarantee absolute safety. I further understand that I share responsibility for my safety.

I acknowledge that attempting adventure activities with an old or preexisting injury or medical condition could aggravate said condition or injury.

Further, I waive any claim that may arise against the camp and/or employees as a result of participation in the program, except for those that are a direct result of gross negligence of the camp or its employees. I give permission for the registrant to be photographed and/or video taped for promotional purposes of the camp.

### **Participant Signature (parent/guardian if participant is a minor):**

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# High Ropes Participant Health History Form

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

PLEASE READ: This form is intended to remind participants of the seriousness of attempting adventure activities with an old or preexisting injury, a heart condition, or other condition which might be aggravated by the event.

<u>QUESTION</u>	<u>RESPONSE</u>		
1) Any pre-existing injuries (ankle, knee, back, neck, etc) that may be aggravated by participating?	YES	NO	
2) Taking any current medications?	YES	NO	
3) Any heart or lung problems?	YES	NO	
4) Do you have high blood pressure or diabetes?	YES	NO	
5) Do you have allergies (bees, insects, plants, medications, etc)	YES	NO	
6) Do you have any physical limitations?	YES	NO	
7) Current level of activity at home	LOW	MEDIUM	HIGH

If you answered YES to any question above, please discuss that item with the staff member that takes your registration.

Please include any additional information that you feel is relevant: \_\_\_\_\_

Participant Signature (parent/guardian if participant is a minor): \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_